A CASE OF FÆCAL ACCUMULATION IN THE RECTUM AND COLON: COMPLETE OBSTRUCTION OF BOWELS SUPERVENING: OPERATION: RECOVERY.

By PRICE MORRIS, L.R.C.P.Ed., L.F.P.S.G.

During the month of August, 1877, I was consulted by a young lady, aged 24, who complained of symptoms of indigestion, occasional vomiting, etc., for which I prescribed. Finding, on passing her home about a week afterwards, that she was no better, I asked her to undress herself, so that I might properly examine her. To my great astonishment, I found that she had large, nodulated, firm, painless, movable tumours, occupying the lower part (and chiefly the left side) of the abdominal cavity. There was no gastric tenderness, menstruation had been regular, the bowels were being moved—in fact, there existed a kind of spurious diarrhœa. I considered it advisable at once to examine the rectum, when I found that this was tremendously distended, and packed full of dry, nodulated, earthy, fæcal matter, the anus being in a continual state of patency, due to the paralysis of the sphincter by mechanical distension. So much was the rectum distended, that a child at full period could easily have passed through it. Before going any further, I had better state that this individual, when a child, was in the Denbigh Infirmary, under the care, I believe, of Dr. Turnour, for accumulation in the bowels.

Getting the patient on the edge of the bed, covered with a sheet of oil-cloth, and using plenty of soaped warm water, I diligently dug away at this mass with my finger (which I think better and safer than a spoon) for a considerable length of time, finding that the mass was gradually descending as it was being removed below. Suffice it to say, that in this way the whole masses in the colon and rectum were cleared.

I cautioned the patient now about taking occasional aperients, and an enema to prevent a recurrence; but this she failed to do, so that after losing sight of her for about eighteen months, I was called to her again.

This time I found her just in the same state, applied the same treatment, but not with the same result, inasmuch as a mass was left in the sigmoid flexure of the colon, which would not descend into the pelvis. This could be felt by introducing a long tube, against which the point would impinge, but which would give way under a little pressure. Injections were of no avail, coming out as administered, owing to the compactness of the mass. After this attempt to clean the bowels, symptoms of complete obstruction supervened, as evidenced by her vomiting every meal she took, as well as a total stoppage of any fæcal discharge from the bowels.

These symptoms were not accompanied by any greater distension or tenderness of the abdomen, neither was there any additional pain; and in spite of the administration of various kinds of purgatives and medicines, as well as enemas, they continued persistently for several weeks. The patient, in the meantime, was getting rapidly emaciated, so much so that, before long, death from starvation must take place.

At this critical period her parents asked me one day if I would have any objection for her to see a very eminent provincial surgeon, which, of course, I gladly consented to. I wrote a full history of the case for her to take with her, which the above gentleman kindly acknowledged, with the remark that it was a very extraordinary case, and that he had not made up his mind what to do. In a few days more I received another communication, stating that, upon further examination, he found that the case was beyond the reach of surgery, and recommending a trial of large doses of aloes. The patient returned home, and tried the above doses for a fortnight, but each dose came back.

Whilst she was away, an idea on one occasion suggested itself to my mind of doing something for her. The idea was to introduce my hand into the gut, and to push it up as far as possible, with the intention of getting at and removing the obstruction. After apprising her and her parents of this—stating that, if it was not successful, she would be left in the same state as at present—I operated, with the assistance of my old master, Dr. Davies, of Llanfair Talhaiarn, and Dr. Roberts. My intention was to dilate the anus; but, finding this impracticable, under chloroform, I divided the whole structures back to the coccyx. Now I could easily pass my hand; and Dr. Roberts passed a long tube in by my wrist, through which warm soaped water was injected. At the top of the pelvis I came across the big mass which I had so often felt and vainly attempted to remove, but now I could easily crush it. The arm was now withdrawn, when the whole was expelled. After reintroducing the arm, I found that the colon was in a very abnormal condition, because, instead of there being an ascending, transverse, and descending colon, it was one tremendously distended chamber, and with my whole arm introduced up to the axilla, I could, on account of her great emaciation, investigate and manipulate every part of the abdominal cavity, with the other hand externally. Strange to say, in the neighbourhood of the right iliac fossa I found an opening of an oval shape, large enough to allow the passage of a good-sized plum (an inch and a half long), with a well-defined margin. This was plugged with a lump of hard fæcal matter, which was removed and crushed in the large amount of water which had by this time been injected. Every part was now thoroughly examined; and, after satisfying myself that there could be nothing more, the arm was withdrawn. Sutures were carefully inserted, a soft elastic catheter placed in the bladder, and by-and-bye a large dose of opium given. Vomiting occurred next day, due, no doubt, to chloroform; after which she went on for a fortnight, fed upon liquid nourishment, without any vomiting. At the end of this time, I detected a doughy kind of swelling in the left iliac fossa, which, I thought, must be the result of what she had been eating; and in a few days more, upon removing the sutures and catheter from the bladder, fæcal matter was found in the rectum, which was all easily removed by an enema.

After this, she got up, gradually resumed her ordinary diet, and I took care to watch her carefully for some time, with the satisfaction to find that the bowels gradually resumed their normal functions without the use of aperients or enemas; the bowel, no doubt, as time went on, in spite of its extraordinary distension, resuming its tone and contractile power; whilst the inestimable advantage of a sphincter capable of discharging its fuctions has been regained. In this way the patient has kept for over seven years. Lastly, what the above opening was, unless it was the ileo-cæcal valve, I am at a loss to know.

FIVE CASES OF PULMONARY PHTHISIS TREATED BY THE "BACTERIUM TERMO" SPRAY.

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Seeing an article in the British Medical Journal of October 2nd, headed "Failure of the Bacterial Treatment of Consumption," I think it only fair to state what has been my experience in five cases subjected to this treatment. I can scarcely say that failure has been the result of my efforts, for in two of the five cases marked improvement resulted, which continues up to the present time. The first case was that of a painter and paper-hanger, aged 43. He had lost his mother and a brother of consumption. In September of last year he caught cold, and had been ill until the time I saw him in April. He then had lost over a stone; his appearance was typical of advanced phthisis—great shortness of breath, bad cough, sputa sinking in water, with much pain in the chest, and continual diarrhœa. Physical signs showed breaking down in the upper part of the left lung, with a cavity under the left clavicle, clicks in the right apex, and commencing disease throughout the whole lung. Having obtained a pure cultivation of "bacterium termo" in a meat-infusion by means of an incubator, kindly lent me, I injected six ounces a day in three sittings into the lungs, with a fine spray-producer. While pumping the spray, the patient was made to take as deep inspirations as possible; these were quick and shallow at first, but as time went on they became very deep and long.

At the end of a fortnight, his condition had greatly improved; the diarrhœa had ceased, the cough and expectoration were less, the appetite had become better, and the physical signs showed more natural breath-sounds.

At the end of a month, his condition was sufficiently improved for me to allow him to go back to his work—that of painting and paper-hanging—at which trying occupation he has been employed ever since. I, however, took the precaution of continuing the spray twice a-day for three weeks more.

In this case, although I never could get the patient's lungs free of disease, yet a good deal of repair had taken place, weight had been gained, and a healthy appearance substituted for his consumptive look.

The second case was that of a girl, aged 20, who came from a distance to consult me. She had lost several members of her family from consumption. Her lungs were very weak, and there was disease in both apices, but no cavities. I put her under treatment, and in ten days she had so much improved that she went home to enable her sister,

who was in a worse condition than herself, to come and undergo the treatment. The sister, however, was too ill to be moved, and going to see her at the house, I found she was very far gone in a most rapid form of disease. I persevered with her, but could never find that she benefited in any way, and she died three weeks from the time that I saw her first. The sister continues to keep well.

The fourth case was that of a sailor, aged 53, with a bad family history. There was advanced disease in both lungs, and extreme prostration, and loss of weight had been very rapid. When first put under treatment, he improved somewhat, but soon aphthous patches appeared in the mouth, the unhealthy condition of which seemed only to be aggravated by the spraying of putrid matter into it, and he died in less than a month.

The fifth case, a lady living in Lancashire, I have never seen, but her medical man has minutely described her condition to me, and has sanctioned her undergoing my treatment; she has been suffering for some years, and had nursed a brother dying of the disease shortly before she herself became affected. She has most religiously and minutely followed all my directions, but though her general health has slightly improved, her medical man states there is no improvement in the physical signs of her chest, but rather the contrary. The conclusions I draw from a trial of this treatment are, that the forced deep inspirations necessary are very beneficial in some conditions of the chest; that when diarrhœa is present it checks it, improving the appetite as a rule; that it has a tendency to diminish expectoration, and an influence for good in cases not too far gone, but that in rapid forms of the disease, and where much excavation exists, it is useless.

TOBACCO AMBLYOPIA IN WOMEN.[1]

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I WISH to make some remarks on a form of bad vision caused by the use of tobacco, and will call your special attention to seven cases occurring in women which I have observed at the Manchester Royal Eye Hospital. All complained of a rather rapid deterioration of vision, and the fundi were either quite normal or only showed very insignificant changes. How then was the diagnosis made certain in these, as it is in all cases of tobacco amblyopia, by the presence of a central colour scotoma? This test is easily applied by causing the patient to cover one eye, while with the other he or she gazes steadily at the eye of the examiner, who then brings a small piece of red or green paper, fixed on the end of a pen, into the centre of the patient's field, and notes the presence or absence of the patient's perception for colour in that part of his field. This test, so easily applied, is, I believe, an infallible test of bad sight produced by tobacco; and, further, I have never met with a central colour scotoma in a person who did not use tobacco, though I ought here to say that some such cases have been recorded. In my experience, then, a case of central colour scotoma is synonymous with tobacco amblyopia. I cannot too strongly insist upon the necessity of applying this test in all recent cases of failure of sight, whether in men or women, where the ophthalmoscope reveals a normal, or nearly normal, state of the fundi, and you will be astonished how large a proportion of such cases will fall under the head of tobacco amblyopia. Hardly a day passes at the Royal Eye Hospital without a case turning up. We must not be thrown off our guard by any slight changes we may find in the fundi, and at once conclude that they are the cause of the defective sight, for they may be only accidental changes in a case of tobacco amblyopia, and have little or nothing to do with the bad sight. For example, in three cases I have seen a solitary retinal hæmorrhage confined to one eye, the vision being equally diminished in both; in several, fine vitreous opacities; in others high degrees of myopia with posterior staphyloma, and in one woman I at first imagined the bad sight to be due to the presence of a few very minute white ticks at the maculæ which were only made out with difficulty by the erect image. In this case I afterwards found a colour scotoma, and elicited the fact that the patient smoked. Again, I have seen two cases in patients with well-advanced locomotor ataxy, and have no hesitation in saying that it was tobacco, and tobacco alone, that was the cause of the bad sight. Professor Hirschberg, in a paper on Tobacco and Alcohol Amblyopia, in the second volume of the JOURNAL for 1879, says "we never meet with the disease in women," and the only cases I have seen recorded besides my own were published by Mr. G. A. Berry in the *Ophthalmic Review*, April, 1884. I may further add that at the Royal Eye Hospital the first diagnosis of the affection in a women was made rather less than twelve months ago.

[1] I have written more fully on this subject in a paper on "The Field of Vision," *Med. Chron.*, November, 1885.

ACUTE PERITONITIS: OPERATION AND RECOVERY.

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THE subject of acute peritonitis and its treatment is always interesting. The following case is, I think, especially so from the completeness of its history, the promptness shown by the medical attendant in his diagnosis of the patient's condition, and the success attendant on the operative measures adopted.

On Friday, November 12th, Dr. Leslie Phillips asked me to see a married lady, aged 21, whose previous history was as follows. Her first labour occurred on September 28th, 1886. Forceps were applied for uterine inertia. Three days after delivery, she developed pain and tenderness in the left iliac region, with fever. From this date until the end of October, when the lying-in attendance ceased, she had intermittent feverish attacks, with pain and tenderness in the same situation. On vaginal examination, there was a feeling of resistance on the left side of the cervix, but this was not well marked.

On November 11th, at 11 P.M., while lying quietly in bed, nursing the baby, she was attacked by a sudden pain in the left side of the belly, which caused her to vomit; she continued in pain all night. Dr. Phillips saw her at 12 noon, diagnosed escape of matter into the abdomen (thinking it a phlegmon of the broad ligament, or a pyosalpinx), and, a few hours later, requested me to see the patient with a view to opening her abdomen. At our consultation we found the patient very feverish, her temperature being 104° Fahr., and her pulse 140. There was some distension and great tenderness of the abdomen, and, on examination by the vagina, an ill defined swelling was found behind the uterus, acutely tender to the touch. The uterus itself was fairly mobile, and of normal size. No vomiting had occurred since the morning, but the countenance was anxious, and the condition evidently grave.

Some peritonitis was undoubtedly present, and in all probability this was of pelvic origin. In view of the mobility of the uterus and the absence of continued vomiting, I hardly thought that the symptoms justified a more accurate diagnosis, but, as the sequel showed, the original one formed by Dr. Phillips, of rupture of an abscess on the left side, causing acute peritonitis, proved to be entirely correct. We advised early operation as the only proper treatment for the patient's condition, and her husband very wisely readily consented.

The next morning, November 13th, at half-past nine, I opened the abdomen (Dr. Phillips assisting me, and Dr. Potts giving ether). I found that the lower part of the abdomen and pelvis contained seropurulent fluid, which welled up into the incision as soon as the peritoneum was opened. The appendages on the left side, together with the intestines, omentum, and uterus, were matted together into a mass in which it was difficult to distinguish the different structures. The omentum and tube were first differentiated, and the Fallopian tube, much thickened and inflamed, was brought to the surface. The corresponding ovary, which was adherent to the top of the uterus, and had therefore been beyond the reach of vaginal examination, was carefully separated, and both tube and ovary were withdrawn outside the incision. The ovary was then seen to contain an abscess in its substance, which had broken by two small ulcerated openings, from which thick yellow pus was freely oozing. The affected ovary and tube were then removed; the broad ligament pedicle, which was very thick and fleshy, being transfixed and tied in two halves with silk. The ligature cut through the tube, but held the rest of the stump well, so that but little hæmorrhage occurred after the ligature was applied. As the appendages on the right side appeared to be perfectly healthy, these were not interfered with. The abdomen was well washed out with warm water; and, before closing the abdominal incision, a drainage-tube was inserted in the pelvis.

The progress of the case since the operation has been very satisfactory. The drainage-tube was removed on the third day. The patient is now (November 28th) convalescent, her temperature and pulse are normal, and her appetite is good.

To recapitulate briefly the leading features of the case: We have a history of recurrent febrile attacks, with left iliac pain following confinement. Seven weeks after the labour, a sudden attack of acute abdominal pain, accompanied by vomiting, and passing on into symptoms of general peritonitis, in which, however, the febrile element was unusually marked. Proof, on laparotomy that a burst abscess was the cause of this, and rapid recovery on removal of the abscess-sac and cleansing of the peritoneum.